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See page 18 for cover story.
DEPARTMENTS

From The President
Michael McCall, MD

Commentary
Denial is for dodos
Mary G. Barry, MD

Reflections: An examination of conscience
Teresita Bacani-Oropilla, MD

In Remembrance: Mohammad Shafii, MD
Allan Tasman, MD

Physicians in Print

We Welcome You

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The New Year and the month of January call us to take a moment to reflect on the past and set goals and expectations for the future. As you may know, the month of January was named for the Roman god Janus, a mythological deity with two faces, one looking backward and one looking forward. Janus was the god of doors, gateways and the sort of beginnings that ensure good endings.

As physicians and medical professionals, we have many recent successes to celebrate consistent with the GLMS mission to promote the science, art and profession of medicine, including the research occurring in our own community at the Cardiovascular Innovation Institute. As we look to the future, research and development are on track to continue to lead our practice to new and cutting-edge ways to treat, heal, cure and comfort our patients.

Yet, a look to the future also identifies one of our greatest vulnerabilities in the health care fields: shortages of nurses, physicians and health care professionals. In the Health Resources Service Administration report, *Projected Supply, Demand, and Shortages of Registered Nurses: 2000–2020* (BHPr, 2002), the authors identify a trend that indicates the nurse shortage in 2003 was approximately 168,000 full-time equivalents of registered nurses and project a shortage of more than a million FTEs by 2020. Similarly, researchers noted that demand will outpace supply for both primary care physicians and specialists through 2020, as detailed in the HRSA report, *Physician Supply and Demand: Projections to 2020* (BHPr-27-2). Taken in concert, both reports indicate a need for focused efforts to recruit, train, support and mentor health care students to meet the future needs of our society.

In the Louisville Metro area, we are fortunate to have several initiatives promoting health care careers and supporting students as they pursue their education in their fields of study. Other projects that GLMS works with such as The Healing Place and Hand in Hand Ministries (Supplies Over Seas) also promote education for their clients. One organization in particular has been quietly supporting these goals and deserves recognition. Family Scholar House, formerly known as Project Women, provides housing and educational support for single-parent college students and their children, assisting them in breaking the cycles of poverty and homelessness while supporting their career goals. Interestingly, 70 percent of the student parents at Family Scholar House pursue careers in health care. And, they do so with the support of academic advisors, mentors and job-shadowing opportunities that promote their success in the classroom and in the workplace.

As we as a group fulfill our commitment to advocate for the health and well-being of the community, we must also advocate for the organizations that share our common goals. Family Scholar House is uniquely poised to help us meet the growing demand by supporting the future health care professionals who will live, work and practice their skills in our community. I encourage you to learn more about Family Scholar House by visiting www.familyscholarhouse.org or contact them for a tour of their new Louisville Scholar House campus, which provides housing for 56 single-parent families and childcare for over 150 children in our community.

As Janus promoted, good beginnings can lead to good endings. Looking forward allows us to prepare for the future – a future in great need of health care professionals committed to our core values.
Denial is for dodos

out because they could not flee from adapt. If we do not soon remedy our state's denial of the true costs of cutting human greed. Flightless, they could not human services to balance the budget, then dodos will not be alone in the cemeteries.

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Bridgehaven has had to turn away more than 30 patients who could not pay dollars, on top of a 13-year span without

dent, said, “Real people can't access our services. We can't account for what happens to all these people.” Katharine Dobbins, associate director of Wellspring's psychiatric crisis stabilization units, told Ms. Yetter that services will be reduced because of state funding cuts. When patients in crisis have nowhere else to go, they end up at U of L's ER, but not always in U of L's beds. Psychiatric crisis stabilization units, which were running at full capacity, have to turn away patients who can't pay."

Psychologists describe denial of impact, healthy to me; if we can't afford mosquito-spraying efforts, we may be forced to pay for more encephalitis cases. Real people can't access our services. We can't account for what happens to all these people.” Katharine Dobbins, associate director of Wellspring's psychiatric crisis stabilization units, told Ms. Yetter that services will be reduced because of state funding cuts. When patients in crisis have nowhere else to go, they end up at U of L's ER, but not always in U of L's beds. Psychiatric crisis stabilization units, which were running at full capacity, have to turn away patients who can't pay."

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Denial is for dodos

As dead as a doornail, as dead as a dodo: dodos are extinct, and they died out because they could not flee from human greed. Flightless, they could not adapt. If we do not soon remedy our state’s denial of the true costs of cutting human services to balance the budget, then dodos will not be alone in the cemeteries.

Freud said that we use denial to protect ourselves from uncomfortable and unpleasant realities. This sounds a whole lot like the Ky. Legislature, who seem to believe that they can strip health and human services and educational funding to the bone, and then expect everyone to just get over it. In November, Deborah Yetter reported in the C-J that the U of L Geriatric Psych unit had to close after public mental health funding was cut by $20 million dollars, on top of a 13-year span without funding increases. She reported that Bridgehaven has had to turn away more than 30 patients who could not pay since the new fiscal year started on July 1. Ramona Johnson, Bridgehaven’s president, said, “Real people can’t access our services. We can’t account for what happens to all these decisions.” Katharine Dobbins, associate director of Wellspring’s psychiatric crisis stabilization units, told Ms. Yetter that services will be reduced because of state funding cuts. When patients in crisis have nowhere else to go, they end up at U of L’s ER, but not always in U of L’s beds. Dr. Allan Tasman, chair of U of L Psychiatry, noted that U of L had admitted 2,465 out of 6,350 people evaluated on its emergency psychiatric service in the fiscal year ending June 30, with 750 more people seen than in 2007. Ms. Dobbins said, “More people are going to end up in the ER, more people are going to end up in jail, and more people are going to be ending up on the street without treatment.”

Patients not in crisis but in dire need of help get painfully little now. Dr. Scott Hedges of Seven Counties has already dealt with drastic cuts in his staffing, and will be facing even more, because Gov. Beshear has estimated a nearly $500 million dollar budget shortfall for 2009. State social workers are under a hiring freeze already. The state universities have already taken 3 percent cuts for the past two years. Facing new 5 percent cuts across the board is not the way to grow a trained and skilled work force. Where will the ax fall next? The last time that Metro Louisville had to reduce EMS’s budget, our average response time went up by 41 seconds — not bad if you are breathing, very bad if you are not. The police and the firemen are negotiating with Metro government and at this writing are resisting every effort at pay and benefit cuts; since their salaries are union-protected, other Metro workers may have to take up the slack. “Less sanitation” does not sound healthy to me; if we can’t afford mosquito-spraying efforts, we may be forced to pay for more encephalitis cases.

Denial comes in many forms. Psychologists describe denial of impact, wherein we refuse to recognize the harm our actions cause others, so as to minimize the guilt. We can make poor decisions all day and never feel the pain of the people those decisions hurt. The C-J also reported in November that since January 2006, some of our legislators have spent $1.3 million dollars on “educational trips,” with only 25 of them accounting for half that total, and 30 of them billing for none at all. State Senate President David Williams received nearly $40,000 in reimbursement for travel expenses and salary, second only to Sen. Tom Buford, whose first 29 trips this year have already cost us $43, 416. Of course our legislators faced no budgets cuts — in 2008 they gave themselves a 7 percent raise. Do you think any of this educational travel was designed to help these lawmakers feel the pain of the poor, the crazy, the sick and the desperate? Do you think any trip involved outings to 12-step groups, where denial is routinely overcome with the help of one’s comrades in suffering? How many trips required these legislators to tour rural health clinics where overworked nurse practitioners provide maternal and child care to hundreds of high-risk families a year? One does wonder, since there just aren’t that many of the rural poor in Las Vegas or Napa Valley.

At least Sen. Buford was recently quoted in the Courier as one of only two Republicans favoring an increase in the cigarette tax. On the other hand, Sen. David Williams has repeatedly said that, “I am not inclined to raise taxes.” He has so far stonewalled all attempts in the Senate to pass another cigarette tax increase, and has favored cutting services as opposed to raising revenue. Sen. Damon Thayer, R-Georgetown, said, “I just ran a campaign where I got 61.7 percent of the vote and I told my constituents that I’m not for raising taxes.” Apparently, his constituents think that

Continued on page 8
roads, schools and clinics arrive for free, another manifestation of denial: if we refuse to face reality, maybe it will go away.

Sen. Ken Winters, R-Murray, chairman of the Education Committee, said that he “would need to see data to support the claim that increased cigarette taxes curb smoking.” It’s typical of this state that the person who oversees education funding has managed to deny the findings of mountains of research on the subject. In every state that has raised its cigarette tax, pack sales have gone down steeply. Youth smoking rates are tightly tied to cigarette cost and dropped by 15 percent over the last decade as taxes rose in many states. Kentucky has the highest lung cancer death rate and the most smoking. We lead the nation in pregnant teenage smokers and are close to the worst in premature births. Smoking cessation reduces deaths from lung cancer, heart attack and stroke. Philip Morris executives have testified that, “A high cigarette price, more than any other cigarette attribute, has the most dramatic impact on the quitting population. It is increased taxation that alarms us the most.” And Sen. Winters is unconvinced? That is denial in its most basic form: “Don’t confuse me with the facts.”

If our lawmakers have any conscience, any feeling for the needs of the people of this state, they should cleave to the principle of government of the people, by the people and for the people. What the people need is more care. Taxing cigarettes at 30 cents more per pack raised our tax revenue from about $20 million to about $165 million/year after the 2004 increase. Raising that tax to a dollar a pack would raise another $185 million, to about $350 million per year, as per the UK Department of Agriculture. $350 million would go a long way towards funding mental health centers, prenatal care, smoking cessation programs, lung cancer research and university budgets. The Ky. House of Representatives has figured this out. The Senate is still mired in denial. Thomas Jefferson said that the people get the government they deserve. If the Senate once again stalemates the cigarette tax increase, we can trade in our state Cardinal for a Dodo.
When the vaccine for Human Papillomavirus was approved for use in the U.S. in June 2006, health care providers everywhere celebrated the possibility that through vaccination, we might be able to eradicate cervical cancer just as we had eradicated smallpox and polio in developed nations. Enthusiastic public health officials and health care providers even suggested that vaccination should be mandated by the state or national government for all pre-teen and teenage girls. However, in the Aug. 21, 2008, edition of the New England Journal of Medicine, Charlotte J. Haug, MD, PhD, made a sobering argument against large-scale vaccination programs based on the fact that there are many unanswered questions about the vaccine’s cost effectiveness and long term efficacy.

So what is a girl to do? So what is a government to do?

In order for a girl (or her parents) or the government to make the right decision, both need to have a good understanding of what benefits and risks this vaccine confers to the individual and to the population at large. Both also need to understand that sometimes the benefits to an individual may not be as great as the benefits to the group and vice versa.

We know this about the human papillomavirus and the vaccine for it:

1. 99.7 percent cases of cervical cancer worldwide are caused by HPV
2. The risk for developing cervical cancer is higher for those with:
   A. Early age at first sexual intercourse
   B. Higher number of lifetime sexual partners
   C. High parity
   D. Use of oral contraceptives
   E. Smoking
   F. Male partner with multiple other sexual partners and who is uncircumcised
3. 50 percent of all cervical cancer cases in the U.S. are caused by HPV 16. About 15 percent are caused by HPV 18.
4. 90 percent of all anogenital warts are caused by HPV types 6 and 11.
5. The human papillomavirus quadrivalent vaccine currently available protects against types 6, 11, 16, and 18.
6. The vaccine has been shown to effectively reduce precancerous cervical lesions (CIN 2/3), but not cervical cancer itself. This is because it takes about 10 years from the initial infection with HPV until the development of cervical cancer, and the vaccine has not been out long enough to track cases of cervical cancer.
7. Because it takes around 10 years for HPV infection to progress from infection to cancer, routine annual pap smears are effective in preventing cervical cancer by detecting it in its precancerous phases.
8. Vaccination does not eliminate the need for routine pap testing, but it may allow less frequent screenings for some individuals.
9. HPV vaccine is as at least as safe as other routinely given vaccinations.
   
   Serious reactions that have been reported with the HPV vaccine include severe allergic reactions and Guillan-Barre’ syndrome. These are rare. The cases of Guillan-Barre have not been shown definitively to have been caused by the vaccine.
10. Condoms do not fully protect against the transmission of HPV.
11. The following remain unknown:
   A. Will booster shots be needed?
   B. Will other serotypes of HPV emerge as causes of cancer?

As a public policy issue, mass vaccination against HPV offers a novel opportunity to study how manipulating the immune system can impact the incidence of cervical, other anogenital cancers, and possibly head and neck cancer. The knowledge gained could have far-reaching implications in developing preventative and treatment strategies for several diseases. In addition, mass vaccination will lower the incidence of HPV infection even in unvaccinated persons through “herd immunity.” Since fewer people will have the virus, fewer people can spread it to others, and the population at-large benefits. In addition, government mandated vaccination would require a mechanism to educate all persons about the vaccine, so everyone has the same opportunity to choose. If it is not mandated, then many individuals who would be at risk may not have access to this information and therefore would not have the opportunity to choose. However, mass vaccination will require a very large commitment of public funds that could otherwise be used for other health and wellness initiatives that may have more reliable positive outcomes.

Obviously the benefits to individuals vary greatly according to the risk factors they have for acquiring HPV infection, genital warts, and cervical cancer. Since the target group for vaccination...
On September 3rd, 2008, a new organization—the Greater Louisville Value Exchange Partnership—received the Federal designation as a Chartered Value Exchange. Despite a press release from the Agency for Healthcare Quality and Research, this event was greeted with a collective yawn. After all, what is a Chartered Value Exchange and who are these people involved with one in Louisville? Clearly, neither the mainstream media nor the medical outlets played up the significance of this first CVE in the Commonwealth.

Perhaps it is best to back up to the background of the Chartered Value Exchanges before looking for local significance. The concept of “value driven health care” was adopted by the Secretary of Health and Human Services, Michael Leavitt, during the second Bush administration. The concept was that free market forces would prevail based upon information exchange even if the traditional cash for service exchange were altered. According to Secretary Leavitt, health care costs do not follow normal financial market forces because of the insulation of public and private third party payers. People traditionally are insulated from the costs of health care so that the risks are borne by all rather than falling only to those in need. So if we are to have a system of insurance that buffers against change, the theory goes, then we need to have other “forces” to alter patient health seeking behavior and physician responses. The solution fostered by Health and Humana Services is to use transparency as the driver. Since physicians tend to be competitive, then public display of quality, patient experiences, and costs were anticipated to impact the cost of care.

In August of 2006, then President Bush, announced HHS’ “four cornerstones” which include quality transparency, cost transparency, development of incentives for physicians and for patients, and an interoperable electronic system for data exchange. To help encourage the development of these principles, Health and Human Services developed tools to bring these four cornerstones to the community level. That process was the development of the Chartered Value Exchanges. The Health and Human Services Web site (http://www.hhs.gov/valuedriven/communities/valueexchanges/exchanges.html) provides the rationale for the development of CVEs:

Local collaboratives play a vital role in improving the quality and cost-effectiveness of health care. The first step in building the collaboratives has been to recognize multi-stakeholder entities as community leaders and encourage them to become Chartered Value Exchanges. These would:

- Embody all the characteristics of the Community Leaders
- Have well defined and balanced stakeholder representation including community purchasers, health plans, providers, and consumers.
- Keep stakeholders engaged in ongoing collaboration and serve as hubs for sharing information.
- Use standard performance information to engage providers in improvement, help consumer decision-making through public reporting, and promote effective payment policies and consumer incentives.
- Share promising practices and lessons learned and continually refine efforts.

As in the other 24 communities across the country that have become Certified Value Exchanges, the Louisville program brings together representatives from the medical community (i.e. GLMS), business and labor (i.e. Ford-UAW), payers and local government representation (e.g. Healthcare Excel). The CVEs all are based upon three principles. The first is that health care is a local phenomenon so that local people can better understand the landscape. The second principle is that broad access to accurate, meaningful information will stimulate improvement by engagement of physicians, hospitals, and consumers. Finally, the third principle of the CVE is that learning can occur between CVEs if there is a communications process.

The GLVEP intends to dovetail with other groups measuring physician efficiency and effectiveness. This include the Greater Louisville Medical Society, the Kentuckiana Health Alliance, and other such groups.
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When I was a preteen in a boarding school run by nuns, we had a ritual incorporated in the evening prayers at the end of the day. It was called examination of conscience. Basically, for a few minutes, one reviewed the good, the bad, and the neutral deeds of the day and resolved to do better the next. In retrospect, it was a clever way to teach introspection and responsibility for one’s actions.

As applied to later years, this discipline had wider implications. As one grew older, the review could be of the day, an activity, an event, or one’s decisions and phases in life. The resolve to do better in the future speaks volumes for itself.

The old year is fast coming to an end. As evidence, the beautiful sun-bathed golds and reds adorning the trees of Indian summer have given way to bare branches whipped by the cold wet winds of winter. It has been a spectacular year in many ways, with all of us involved not only with our own personal triumphs and tragedies but with the country’s and the world’s as well. Instantaneous worldwide communication has made us privy to the good and bad of the near and far, whether we like it or not.

Thus, we learned that the local dry windstorms that wreaked havoc to our neighborhoods also brought out the innate kindness and good will of each to the other, when given a chance. The highly contested nomination and election contests that dominated our media for months energized people to come forth with their views and discuss touchy subjects with passion. It showed to what extent people use or compromise truth to advance their causes or to hurt adversaries. It revealed that some had to choose whether they should even be involved at all.

The shaky financial status of the nation opened our eyes to the greed and inequity of our institutions and the need for concerted efforts to rectify the blunders that had been made. The suffering of the impoverished among us and of other countries have become our worries too. It would have been more convenient if we did not know about them, but now that we do, what are we going to do about them?

It is said that “Charity begins at home.” Should it stay there? When is enough, enough?

The new year is upon us. A fresh page in the Book of Life is being presented to each of us. With what shall we fill it? Would an examination of conscience help?
Are there skills you wish you had been taught in residency that would have helped you in your current practice? Perhaps you would have liked to have had some education on the business side of medicine, management, or procedural skills. The pediatric residents at the University of Louisville wanted additional education, too. They wanted and are receiving education in advocacy. They are learning by doing, and in doing so, they are making waves, getting noticed, and setting a national precedent.

In the spring of 2006, Dr. Joshua Honaker, now President of the Kentucky Chapter of the American Academy of Pediatrics, who is also a private pediatrician and recent graduate of the University of Louisville’s Pediatric residency, recognized that residents need more experience and education on how to advocate for their patients. He brought up an idea to the program director and department chair at the time, Dr. John Roberts and Dr. Gerald Rabalais, respectively. In conjunction with the Kentucky Chapter of the AAP, Dr. Honaker proposed that the residency program develop a hands-on program to teach advocacy to the residents. After this meeting and further conceptual development, his idea became a mission and Pediatricians Urging Safety and Health was born.

PUSH is an advocacy group affiliated with the Kentucky Chapter of the American Academy of Pediatrics. Our goal as resident physicians is to focus on the safety and health of children in our clinics, communities, and the Commonwealth, and one point that sets this group apart is that it has been developed, implemented, and managed by residents.

To take an idea, develop it into a mission, and subsequently convince others that they should believe and take part in said mission is a daunting task. Now consider that to make this mission develop and succeed, you must enlist the faith, time, and energy of a group of newly dubbed MDs who are still somewhat uncomfortable being called “doctor” and hardly feel confident enough to be an advocate. Add in the work schedule, rare free time, and exhaustion that come with being a resident, and it is easy to see how difficult this was. The residents act on their own, receiving no academic credit for their work.

The development of this group has required perseverance, patience, and taking one step at a time. The

Continued on page 14
same spring that the group was initiated, they were successful in aiding the passage of the Graduated Driver License Bill, and by the time I started residency in July 2006, the group had a small, yet loyal, group who spanned all post-graduate years. While in our infancy then, we had monthly conferences with guest speakers to discuss legislative process and advocacy, and at that time, we were actively working on two topics, injury prevention and child abuse. We were urging the passage of the Booster Seat Bill in the state legislature, developing a lecture series on advocacy topics, and developing a separate lecture series on child abuse. Each class of residents chose a topic to be its focus, with my class choosing obesity. Like the other classes before us, we began to research the topic and our state legislative environment.

By the fall of 2006, we had business cards, and each class had one or two residents leading the efforts for particular topics with the help of a few others also interested in that matter. Even though the group had come a long way in a short time, it was definitely suffering the same ills that many groups do, those of stagnation and lack of direction. Fortunately, in October 2007, Dr. Marie Trace, Dr. Honaker and I were able to attend the AAP’s National Conference and Exhibit in San Francisco, and it was there we met together and agreed that the group needed to be reinvigorated. Consequently, it was now my mission to get this group to the next step.

All organizations, regardless of whether they are a for-profit business or a not-for-profit entity, face the issues that PUSH faces. Recruitment and retention of members, working with others to develop a mission statement and associated goals, revamping the organizational structure, finding time for the group to plan and work, and developing plans to effect a change for the better for children in relation to the topics we had chosen, were all issues that we faced.

To get people involved in your mission, you must believe and be able to convey to others that their thoughts and time have value. It is absolutely critical to recognize their accomplishments. You must make it easy for them to be involved. People want to be part of something bigger than themselves. Create ownership within the group and you will create momentum. Those initially disinterested will eventually become active members of your organization. President, president-elect, and committee chairs are to be accountable to each other and also work independently to develop and implement their goals. We have legislative leaders who keep the group abreast of current federal and state legislation that affects children. We have a president-elect who, prior to the presidential year, observes and gains insight from the current president. Dr. Honaker continues to serve as our primary faculty mentor, while other faculty mentors are involved with each class’ topic. The following are key faculty members who are involved in PUSH: Dr. Lawrence Wasser, Dr. Judy Theriot, Dr. Fred Warkentine, Dr. Pradip Patel, and Dr. Lisa Pfizer. Involvement is not a program requirement; rather our residents participate because they know that a commitment to advocacy is a worthwhile investment in the lives of their patients.

I’ve detailed the history of PUSH to illustrate the importance of the process. As I and the other residents work on the progression of the group, we learn about the intricacies involved with promoting solutions to the important health concerns facing our patients. More importantly, we learn about leadership, teamwork, strategic planning, delegation, and how to surpass the barriers in the way of progress. Just as the Olympic creed states, “It’s not the triumph, but the struggle.”

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The Dr. Richard Spear Memorial Essay Contest: 2009

It’s January, I know, I know – you’re not skiing or swimming, you are sunlight-deprived, and people with influenza are wandering like zombies through your office. You must escape, stretch out and read. And if you can write, cheer up! You could win big money: we are very pleased to announce the second edition of the Dr. Richard Spear Memorial Essay Contest.

Dr. Spear practiced surgery here for many years and was renowned for his detailed knowledge of his patients. His colleagues say that his patients trusted him so thoroughly that if another doctor offered advice, they would nod and reply, “Thanks, I’ll ask Dr. Spear.” Dr. Spear lived alone, worked long hours and loved to study history and to read. Somehow he was inspired to leave the GLMS a bequest of $100,000 to fund an annual essay contest. He wished to support good writing about the practice of medicine.

For the first contest we decided to ask you to write about issues in the practice of medicine, especially with local interest. Many of you did, and we had a lovely awards ceremony in Dr. Spear’s honor in September.

This year, we ask you to write about those irreplaceable people who noticed you. They guided you, they goaded you, they taught you the most vital lessons, and if necessary they led you by the nose. They are the doctors without whom you would not be the physician you are today: your medical mentors.

Tell us about them, about the lessons learned from them, the patients whose care they orchestrated, the medical magic that they performed. Let us know what they hath wrought, and what it meant to you.

You have between 800 and 3,000 words to tell us in. This must be original, unpublished writing intended for publication only in Louisville Medicine. Our contest is open to all members of GLMS, including medical students, excepting the all-volunteer judges. DO NOT put your name on your manuscript. Enclose it with a separate cover letter with name and title, please, so that we the judges will not know who wrote what. Submit via email to Bert Guinn, our director of communications, at bert.guinn@glms.org or by snail-mail, to the same, 101 W. Chestnut, Louisville, KY 40202.

As judges, we will consider excellence in expression, creativity, readability and clarity. We will consider how well you tell the story, and how well that story harmonizes with our collective medical soul.

We judge by category, and reward accordingly: $1,500 to the Practicing and Retired Physician winner, $1,000 to the Physician in Training, $500 to the Medical Student, and to all-comers, an Honorable Mention gift card and certificate (I want to give one of those big horse-show ribbons, we’ll see).

We’ll publish the winners in the September issue, and publish many others all through the year. Start writing. Your deadline is April 1. We can’t wait to read them.

-Mary G. Barry
The River’s Bend
Medicine is a noble profession, and those who practice it are held in high esteem by our society. Sadly, though, every day, practicing physicians face circumstances that make them choose between nobility and nihilism. This dark time in medicine will continue until a new approach is taken to solving its problems.

Our culture promotes instant gratification, lack of personal responsibility, non-stop entertainment and rampant consumerism. It thwarts people from eating healthy food and exercising. The poor often have access to neither nutritious food nor a safe place to exercise. As a result, our nation and many others face an epidemic of obesity and its co-morbidities: Type 2 diabetes, hypertension, atherosclerosis, sleep apnea, and osteoarthritis, infertility, and some cancers. Tobacco continues to claim hundreds of thousands of lives each year. Heavy-hearted physicians reluctantly prescribe an ever increasing number of drugs, surgeries and devices to combat these lifestyle-induced illnesses.

The pharmaceutical industry constantly barrages physicians with an army of attractive, personable salespeople armed with its own studies well designed to sell its drugs and devices, not necessarily to advance knowledge of the best treatment for disease. This powerful industry vigorously lobbies our lawmakers to be sure its ability to profit off human suffering is maximized. Physicians as a whole have been passively complicit in allowing the pharmaceutical industry to put corporate greed above the common good. As a result, the exorbitant cost of drugs often makes the writing of a prescription an exercise in futility anyway.

Speaking of hard pills to swallow, the health insurance industry surely provides plenty. It is very hard to justify the fact that CEOs of insurance companies make millions of dollars per year, while the average salary for a primary care physician in Louisville is $150,000 per year. It is equally irritating for physicians to receive faxes and letters every day from insurance companies telling them how to save their money, while solo practitioners become extinct due to high overhead and dwindling reimbursement. Some doctors are even excluded from

Continued on page 21
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some plans solely based on economic concerns, while their patients are told it was done due to bad outcomes. The bitterest pill to swallow, however, is when an unfortunate patient with insurance develops a disease that is not covered on their policy and cannot afford a treatment that they desperately need. Sometimes, no amount of documentation, appeals or applications can get the much-needed treatment. Then the patient and the doctor must accept substandard care and hope for the best.

Partially as a result of the high cost of health insurance, physicians are confronted daily by uninsured patients who are in desperate need of help. Our society has neither the callous disregard to let these people die nor the moral will to outright provide for them, so we shift the costs of their care to the paying patients in a sleight of hand that creates the illusion that no one is paying for their care. Madness, indeed!

A massive new industry analyzes physicians’ practice patterns and generates mountains of data, spewing out reports telling them and third party payors how they are doing compared to their peers. These reports are not so much based on quality or patient satisfaction, but on costs to third party payors. Never mind that the data is often incorrect and incomplete. There is much cash to be made by these money changers in the temple of Aesclepios. Because there is no powerful authoritative moral voice for the medical profession to drive them out, physicians must accept them as part of the modern practice of medicine.

New information becomes available every day that the practicing physician needs to know to give the best care to patients. Finding the time to attend CME activities is a real challenge for busy physicians. They want to learn, they love the acquisition of new knowledge, but when do they have the time to read all the journals and attend all the conferences they should?

Lest today’s physicians wring their hands and feel that they are uniquely burdened with dilemmas, consider the plight of their predecessors. Their impulses to relieve suffering were crippled by ignorance, superstition, lack of rapid communication, unavailability of efficacious treatments, absence of ethical and practice standards, and geographic separation from those who needed help most. They faced the same temptations to exploit their patients for personal gain and were often solicited by hucksters and charlatans of a different sort looking to make a buck off the suffering of humanity. They were led by twisted ideologies to use their medical skills to commit heinous crimes against humanity. They were enamored by well-meaning but false science that led to the widespread use of harmful, sometimes mutilating treatments such as frontal lobotomies and bloodletting.

Furthermore, physicians, like everyone else, are subject to the frailties of the human condition. Physicians are subject to stress, boredom, loneliness, substance abuse and physical and mental illness just as other riders on this ferry to eternity are.

Perhaps though, the most essential challenge that confronts physicians in their daily practice of medicine is preserving their sense of professional nobility and rejecting nihilistic thinking that makes...
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them question the value of their work. Sometimes
the floodgates of despair open all at once and it is
truly a struggle for physicians to keep their heads
above the roiling current of negativism.

It is a wonderful testament to the basic good-
ness of humanity that every day good, competent,
compassionate physicians continue to care for the
sick and dying, relieving mundane suffering and
sometimes even performing miracles that preserve
life and restore function in the face of once cer-
tainly fatal and disabling conditions.

So, what can be done to stop the madness that
puts the nobility of physicians’ souls at odds with
their daily circumstances?

Physicians can no longer behave like a river,
taking the path of least resistance while others
with less altruistic motives redirect the flow of
medical practice, placing them at odds with medi-
cine’s basic noble nature. In other words, physi-
cians can no longer be socially passive. Physicians,
as a whole, tend to be a rather philanthropic and
charitable group. The times now, however, demand
more from them than private charity. They must go
beyond that and work as a group for social justice.
recounts the following parable demonstrating this
concept:

*Once upon a time there was a town built just
beyond the bend of a large river. One day some
children from the town were playing beside the
river when they noticed three bodies floating in
the water. They ran for help and the townsfolk
quickly pulled the bodies out of the river.*

*One body was dead so they buried it. One was
alive, but quite ill, so they put that person into the
hospital. The third turned out to be a healthy child,
so they then placed it with a family who cared for
it and took it to school.*

This went on for years; each day brought its
quota of bodies, and the townsfolk not only came
to expect a number of bodies each day, but also
worked at developing more elaborate systems for
picking out of the river and tending to them. Some
of the townsfolk became quite generous in tending
to these bodies and a few extraordinary ones even
gave up their jobs so that they could tend to this
concern full-time. And the town itself felt a certain
healthy pride in its generosity.

However, in all those years and despite that
generosity and effort, nobody thought to go up
the river, beyond the bend that hid from their
sight what was above them, and find out why,
daily, those bodies came floating down the river.

The medical profession is like the well-meaning
townspeople in the parable. At one time or
another, most
doctors have gone
beyond the basic
requirements of
their duties to help
out individual
patients. Some have
done missionary
work. Some have
volunteered at
homeless shelters
and rehab centers. Some have volunteered count-
less hours for our professional societies. Some have
donated large sums of money to charities. These
are noble and commendable efforts. But as a
whole, the medical profession has not controlled
the currents shaping its path. It has not taken the
lead in engineering a new delivery system that
truly benefits both the profession and the patients.
Sometimes, physicians have even been guilty of
promoting narrow self-interest over the common
good.

Continued on page 25
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The glaring injustices in health care delivery drown the physician’s spirit, and speaking out against those can resuscitate it.

Making health care a government-run industry is not necessarily going to solve the problem. However, even in a free market capitalistic society, health care cannot be treated the same as other consumer goods. Humane, compassionate, competent care in times of illness should be valued as a fundamental human right. A society that abandons its ill is heartless and barbaric. It is a moral imperative to demand justice in health care delivery, and if the private sector cannot deliver that, then the government has to step in.

To be sure, developing a medical delivery system that is just, humane, affordable, high quality and sustainable is a Herculean task. It is not, however, an impossible task. The only reason the task has not been done is because there is a lack of will on the part of the profession and society as a whole to get it done. Dedicated people working together can solve medicine’s problems.

The medical profession can be a voice that speaks with moral authority. It can and should point out the excesses of the pharmaceutical industry, the health insurance industry, the health care management industry, the legal profession, the tobacco industry and the food industry. It should vigorously police its own members who behave negligently, incompetently and maliciously. It should demand all entities involved in the health care delivery behave in socially just ways. If a phar-
maceutical company withholds data in order to protect its product’s profitability, it should have to pay heavy fines. The fines should be used to buy vaccines for children or medicines for the poor or uncovered services for the truly needy patient. If an insurance company makes enough profits to give its CEO millions of dollars in bonuses, it should have to use half the money to give drugs to the poor. If an attorney brings a frivolous malpractice lawsuit, he should not only have to compensate the affected physician for income lost and all related expenses, but pay a fine as well. Why not? Why can’t physicians demand such actions?

Of course, the medical profession will only have credibility on these issues if it captains its own ship well. Medical schools will have to assure their students are properly trained. Medical licensure boards will have to weed out bad physicians. Medical societies will have to develop and disseminate standards of care. Hospitals will have to make quality assurance their number one priority.

In January, a new administration will take over in Washington D.C. This presents a timely opportunity to try a new approach. Amidst all the other pressing concerns this nation faces is a health care system whose flaws cause much suffering for patients and providers alike. Imagine what could happen if all physicians were informed, passionate and vocal advocates for their profession and spoke in a forceful, unified and authoritative voice. The injustices that challenge physicians every day could be abolished. The medical profession could finally go nobly around the bend of this river of tears and stop the bodies from falling in it.
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As I have been thinking about Mo’s life, it has been both difficult and easy: difficult to face reality, but easy to find consolation in the person he has always been. In the 12th century, Moses Maimonides, the Spanish philosopher, physician, and scholar, described his views of levels of charity. In the highest level, the individual plays a role in actually preventing the need for charity through the most altruistic of means, by becoming a partner with the ones in potential need, and teaching them, helping them with specific concrete gifts of himself, and becoming part of their life to lift them up and keep them from harm’s way, as they learn to become self-sufficient. This concept is essentially the same from the perspective of Sufism, about which Mo is incredibly knowledgeable. Mo’s life has exemplified this highest way of being in all he has done.

As a loving son, husband, father, grandfather, physician, researcher, teacher, scholar, and poet, he has given himself in many, many ways to those around him, and made all our lives better by it. In discovering knowledge about psychiatric disorders and communicating it to others to help them better understand these often devastating diseases; when teaching, so that others can gain the skills and knowledge he possesses; in caring for patients and their families to relieve their pain and suffering and help assure they gain the tools to prevent a recurrence; and in his life with his partner in all things, his Sharon, his children Jaleh and Taraneh, and his grandchildren Liam and Mitra, and his many friends and colleagues; in all these things Mo has given of his special set of gifts. And what he gives of these to so many, has made us all better people. His enduring wish for those he touches is to ask each of us to be the best we could be. That isn’t always easy. Those of you who knew Mohammad well, knew his intellect, his compassion, his encyclopedic knowledge, his commitment to excellence, his generosity, his tenacity, and his passion. But you will also know what I mean when I say he is perhaps the best negotiator I have ever dealt with. So for me, when my faculty or family think I’m driving a hard bargain, I know they are also getting a little of Mo in me.

As he has shown us how to “make up your mind” with grace and dignity when the time is not easy and not kind, he has given us that gift as well, one of his most important, one that will help each of us as we face life’s challenges. Not only do we who have been touched directly benefit from his gifts of himself, but literally thousands who may never hear his name will gain from what he has taught us about caring for and loving our life’s partners, our families, our friends and colleagues, our patients, and our students. For every patient ever treated by any student he has ever taught, that patient will be treated, even if just a bit, by Mo. Every family member of every patient he has treated will gain from a bit of Mo in their family life. It won’t stop with just one generation; others he has taught will teach in turn, those for whom he has cared will care for others in turn, those he has touched will touch in turn, thus will many generations experience his gifts.

-Allan Tasman, MD
Falling Through the Cracks

Kali Svarczkopf

It began like any other consult on the Heme/Onc service, but it ended up being an experience that will help to form the physician I will become. I was told to go and see a 50-year-old lady who had been recently diagnosed with small cell lung cancer during her hospitalization. I walked into her room, and explained who I was, and immediately a look of relief came over her face. This was not the reaction I was expecting. Not only was I talking with her about her cancer diagnosis, but also I’m not even a real doctor yet. As she went on to tell me her story, I came to realize why she was so happy that someone affiliated with oncology was finally seeing her.

As a waitress in rural Kentucky, she had no insurance, so when she first presented to her local hospital three months ago for shortness of breath and chest pain, she was unable to get follow-up. The ER physician had told her that while she wasn’t having an MI, she did have some suspicious lymphadenopathy that she needed to see her primary care doctor about. Unfortunately, she couldn’t get anyone to see her, so her disease progressed over the next three months. She had to quit her job because she could no longer breathe well enough to perform. She was having increasing difficulty with daily activities and she had experienced significant weight loss. Finally a physician in her hometown told her, “Go to U of L. They’ll help you there.” She had presented to our emergency room and was admitted to the ENT service, so they could biopsy one of the masses in her neck. When it came back as metastatic small cell lung cancer, we were consulted, and she was then transferred to our service. She told me she had known all along she had cancer, and she explained how terrified she was that she was going to slip through the cracks again. She wanted to get treatment, and she wanted to try to get better, and she was willing to do everything she could to do so.

Listening to what she had gone through, my heart broke for her. Here was someone who had really been making an effort to discover what was wrong with her and to try to get the treatment she needed, and she kept meeting brick wall after brick wall. Unlike half the patients I had seen on wards who didn’t seem to care if they followed up or if they took their medicine, here was a lady who no matter what she had done couldn’t get the appropriate treatment because she didn’t have insurance. She was working, an active member of society, and society had failed her. Now she was at such an advanced stage of her disease that her superior vena cava was being constricted, she had brain metastases, and she couldn’t breathe or swallow well because of the enormity of her mediastinal mass. One of the things I had learned while on service was that small cell lung cancer has to be treated within one week of diagnosis to meet the standards of care, and she had been forced to wait three months. I was upset with the physicians in her hometown for not doing anything to help her. I was thankful that someone had finally sent her to U of L, and I wanted to do anything I could to help her understand what was going on and to be reassured that she was going to finally get treatment.

This experience has made it even more apparent to me how flawed our health care system is, and it has made me realize the importance of educating physicians to tell their patients where they can receive care regardless of insurance status. It also made me realize how much patients appreciate it when they have someone to explain what’s going on and to reassure them that they’re going to receive good care. I think this experience will also spur me to become more involved in the politics of health care, as well as encourage me to really listen to my patients. She felt like she couldn’t get anyone to listen to her, and maybe if someone had, she would have been treated more expediently. I’m really happy that I got to be a part of her care, and I think I’ll be a better physician for it.


NOTE: GLMS members’ names appear in boldface type. Most of the above references have been obtained through the use of a MEDLINE computer search which is provided by Norton Healthcare Medical Library. If you have a recent reference that did not appear and would like to have it published in our next issue, please send it to Alecia Miller by fax (736-6363) or email (alecia.miller@glms.org).
GLMS would like to welcome and congratulate the following physicians who have been elected by Judicial Council as provisional members. During the next 30 days, GLMS members have the right to submit written comments pertinent to these new members. All comments received will be forwarded to Judicial Council for review. Provisional membership shall last for a period of two years or until the member’s first hospital reappointment. Provisional members shall become full members upon completion of this time period and favorable review by Judicial Council.

Candidates Elected to Provisional Active Membership

Agan, Melissa D (20288)
John B. Agan
5129 Dixie Hwy Ste 201
40216
448-7853
Pediatrics
University of Louisville

Cook, Jane Catherine (20170)
Darrel Cook
2840 Electric Rd Ste 205-A
Roanoke VA 24018
540-904-1388
Radiology 2005
Michigan State Univ College of Osteopathic Med

Dageforde, David A (1894)
Emily
6420 Dutchmans Pkwy
Ste 200 40205
891-8300
Cardiovascular Disease 1981,2006; Interventional Cardiology 1999;
Internal Medicine 1977
Indiana University 1974

Dragun, Anthony E (20284)
Emily
Brown Cancer Ctr
529 S Jackson St 40202
561-2700
Radiation Oncology;
Radiation
MCP Hahnemann School of Medicine-Allegheny

Ruess, Lynne (20172)
Christopher L. Deryck
2840 Electric Rd Ste 205-A
Roanoke VA 24018
540-904-1388
Pediatric Radiology 1998;
Radiology 1995;
Pediatrics 1991
The Ohio State University

Human Papillomavirus Vaccination

A Matter of Public Policy or Private Preference?

Continued from page 9

- girls and women between the ages of nine and 26 years -- are likely to engage in sexual activity at some point in their lives, few of them would be a zero risk; therefore all of them should be educated about the vaccine. Young women who decide to engage in sexual activity have a good likelihood that the benefits of the HPV vaccine will outweigh the risks. In my opinion, the HPV vaccine is a good idea for girls and women ages nine to 26 years, and perhaps in older women and males who are at high risk of HPV infection.

The government, however, has insufficient evidence to mandate mass vaccination at this time. Vaccination against HPV should not be a condition for admission to school, as is vaccination against polio, measles, rubella, and other casually contagious diseases. Yet, the government has a duty to gather the evidence needed to make good public health policy. The government should educate its citizens about the vaccine and give everyone the opportunity to choose for themselves. Fortunately, the Vaccines for Children Program pays for the vaccine in girls nine to 18 years of age who have no insurance. The Centers for Disease Control and the NIH (not the manufacturers of the vaccine alone) should conduct long-term follow-up studies to answer as many of the unknown questions as possible, so that in the future recommendations about the HPV vaccine can be made with more certainty about the benefits, risks and the cost effectiveness of mass vaccination.

Greater Louisville Value Exchange Partnership

Why Should I Care?

Continued from page 10

But the real carrot that brings this disparate group together is that HHS has promised to successful CVEs that they will have access to Medicare data. That block of data on all of the Medicare transactions in a region is particularly valuable to all of the “stakeholders.” For insurers and consumers, it is seen as the Rosetta Stone to crack the code leading to discovery of efficient and inefficient medical practices. But for physicians, Medicare data is dangerously inaccurate, rife with errors in identification of physicians and the services that they have provided. If the Medicare data is to be provided locally, then local doctors want the ability to review it before publication.

The Greater Louisville Value Exchange Partnership stands as the one entity in the Metro Louisville area that would have access to this Medicare information. That makes the GLVEP to be a very powerful tool. The ability to be able to mobilize information on best practices can be valuable in and of itself. But the real value that brings these disparate groups together is the potential that The Greater Louisville Value Exchange brings to the data. The Board of GLMS and its members will want to know how the Medicare data will be presented and what the initial review of the data shows. There becomes the reason that you, the GLMS member, will want to know what is going on with the Greater Louisville Value Exchange Partnership.
The 57-year-old diabetic patient came to her primary care physician on a Thursday after noticing a non-healing sore on her leg. Her doctor quickly recognized a diabetic ulcer and arranged for a hospital admission. The patient was admitted to a semi-private room on the Orthopedic Floor. Her roommate was a patient who had a total knee replacement the previous day. Her doctor’s admission orders included a consultation with a plastic surgeon and continuation of her home medications, which included Zyrtec 10 mg. However, the ward clerk had difficulty with the doctor’s handwriting and thought the order read “Zyprexa 10 mg.” The following day, the plastic surgeon came in and arranged surgical debridement in the OR for Monday. Over the weekend the patient was noted to be rather sleepy to the physicians on rounds, but the weekend physicians did not know the patient or her normal mental status so assumed it was her normal status.

During surgery the orthopedist was able to obtain wound cultures before the anesthesiologist noted hyperthermia and diagnosed a neuroleptic malignant syndrome. The patient was treated appropriately and transferred to the ICU. It was there that the physicians discovered that the patient was on the psychiatric drug, Zyprexa, which may be associated with neuroleptic malignant syndrome and with malignant hyperthermia. While the patient was recovering, the wound culture returned demonstrating MRSA. By this time the Infection Control team had returned to the hospital on Monday, found the MRSA culture, and tracked down the patient. She was kept isolated in the ICU until stable enough to return to an isolation unit on a Med-Surg. unit. There, an Isolation sign was placed on her door, along with boxes of clean gloves. The antiseptic dispenser was empty but was filled the following day.

Continued on page 32
Food service was feeling pressure from a new hospital policy designed to speed up the delivery of meals so as to ensure that the meals were delivered hot—all part of a hospital “Hospital-ity Healthcare” campaign, To make sure that the meals were delivered rapidly and hot, food service workers wore the same pair of gloves as they went from room to room.

Ultimately the patient had a significant set of adverse drug reactions and three patients on the floor, including the roommate who had the total knee replacement, developed MRSA infections.

There were multiple patient safety issues in this case. Of course, not all safety issues result in harm. But the term “patient safety” refers to the processes of care that result in better clinical outcomes through the avoidance of harm—actual or potential—in the management of patient care. This is an expanded understanding of the term from as recently as a decade ago when patient safety was restricted to concerns over falls, medication errors, or other catastrophic events.

Today, patient safety is a team sport, involving all engaged in direct clinical patient care or organizing that care. It is no longer restricted to the hospital setting but includes processes appropriate for ambulatory care. The scenario above contains several patient safety issues from illegible handwriting causing medication errors, to distribution of hospital acquired MRSA, to delays in care. It also involves the entire process of care from physicians to ward clerks to nurses to food service.

How do we identify patient safety issues? Complications and “near misses” provide the opportunity to identify systemic issues. In the office setting, for example, patient questions may be received by non-medically trained receptionists who place calls on the doctor’s desk in a temporal sequence rather than by medical relevance. Dr. J. Bryan Sexton, at Johns Hopkins, has studied the impact of clinical outcomes from collaborations between physicians, nurses, and other medical personnel. He has found in a survey of doctors and nurses that a root cause of errors is teamwork disconnect. When asked, “What is good teamwork?,“ nurses tend to respond by indicating that, “Teamwork means their opinion is sought out.” Whereas physicians tend to take a more autocratic view; they indicate that “Good teamwork means the nurses do what I say.”

When faced with poor outcomes, often the collaborative effort of team problem solving can resolve issues to improve patient safety. When the physician can bring to the front and back office staff the concern over the order of phone calls on the desk, the doctor can often present the issue in terms of consequences, and initiate solutions. The team may develop a triaging system more likely to be followed than a top-down solution delivered by the doctor, without input from the others. The physician may be unaware of the unintended consequences of an office mandate. In the first scenario, the hospital emphasis on speed in delivery of meals to make patients happier had the unintended consequence of forcing food workers to skimp on infection control practice, and inadvertently fostering the spread of MRSA in the hospital.

Patient safety is a developing medical field focused on improving processes that may be associated with real or potential harm. It is about re-engineering as much as it is about clinical practice. Patient safety evolved by the application of process analysis in the future:

A. Care at the right time
B. Care on the right patient and parts of the patient
C. Care in the right place
D. Care that is the most appropriate for the patients
E. Care that presents the optimal value to the patient.

The Greater Louisville Medical Society has been involved in the patient safety/quality improvement committee, under Dr. John Lewis. This committee of GLMS has invited interested parties from hospitals, rehab facilities, large group practices and eventually non-medical representatives, to a city-wide patient safety effort. The goal is to identify collaborative processes that can result in: “Better patient outcomes from reduction in complications.” LMs
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